coughed. The pillars of the ring and the inter-columnar fascia were so widely separated and attenuated as not to be noticeable. On my first examination the vas deferens was observed passing down half way to the bottom of the scrotum, forming a loop. The spermatic cord was very short—six or seven lines in diameter, and an inch and three-fourths long; firmly attached centrally to the posterior border of the testicle as if it penetrated it, rather than being a continuation of the epididymis. It had a fibro-muscular appearance, and was inelastic. To a superficial examination, the epididymis presented none of its normal characteristics, except on its relative position to the gland. The vas deferens could not be traced to it, the testicle or the cord. Six small arteries were divided with the cord and required ligatures. After a very severe peritonitis, the patient made a complete recovery.

In addition to the many alleged causes for retention of the testis, the facts in the foregoing case make it proper to add another, namely, shortness of the cremaster muscle, by which it seems to have been prevented from passing beyond the external ring. In all recorded cases of undescended and errant testes, observed by us, where excision was practised, they were either less than the normal size or enlarged by cancerous deposit. In the case under consideration, the hypertrophy was fibrous, and resulted from repeated attacks of inflammation. This case is remarkable for the shortness of the cord (an inch and three-fourths), for its inelasticity, and for its attachment, or rather its insertion into the centre of the posterior border of the testicle. The cord and its adjacent tissues were not indurated, nor did it have abnormal adhesions; and, when divided, exhibited very perceptible contractile powers. We have the observations of Chelius and other writers to support the statement that when the testes are retained in the inguinal passage, the cord is long, and lies coiled behind the gland, and that it affords no retentive action against spontaneous descent, or to the obsolete operation of incision and traction to produce the same result.

The case under consideration is evidently an exception to the facts as given by Chelius, and as mechanical impediments constitute the usual causes of non-descent of the testes, the shortness of the cord, its extraordinary and unyielding attachment to the centre of the spermatic gland, are suggested as the causes of its retention in the inguinal canal.

ART. XV.—*Secondary Hemorrhage from Brachial Artery, treated by Compression and Per-sulphate of Iron.* By JNO. STAINBACK WILSON, M. D., Cypress (near Houston), Texas.

A VERY interesting case of primary hemorrhage of the popliteal artery, arrested by compression, reported in the *American Journal of the Medical*

Sciences for July, 1866, page 107, by Eli D. Sargent, M.D., U. S. Navy, reminds me of the following case, which came under my charge while on duty in Winder Hospital, Richmond, Va., during the late war :—

M. S., aged 25, was wounded in a skirmish, November 8, 1863. The ball entered the posterior and outer part of the forearm, two and a half inches below the elbow, passed upwards and inwards, fracturing the internal condyle of the humerus, and making its exit on the inner side of the arm, about the same distance above the elbow as the point of entrance below; thus passing over the course of the brachial artery.

At 11 o'clock on the morning of the 26th, he had a very profuse hemorrhage from the lower orifice of the wound, which was promptly arrested by the application of per-sulphate of iron, in powder, to the bleeding part, and by compression, as follows: A compress of lint was pushed gently into the wound, and then another was placed over this. Next, a long compress of firmly folded cloth was placed over the whole course of the brachial artery, which was held in place by a bandage pretty tightly applied from the ends of the fingers to the axilla. The whole limb was then elevated and irrigation used, by letting cold water drip from a suspended canteen. At 11 o'clock the following night, the hemorrhage recurred, but in moderate quantity; and the blood having coagulated sufficiently to check the hemorrhage before my arrival, the dressings were not disturbed, except so far as to tighten the bandage, which had become somewhat loose. The only additional treatment was a few half grain doses of morphia, with five drops of tinct. veratrum viride, every three hours. On the evening of the 28th, the veratrum, having produced a very decided effect on the pulse and stomach, was discontinued. After this there was no more hemorrhage, and the wound was healing kindly on the 13th of December, the date of last observation.

Remarks.—In treating the above case, I was aware that I was acting contrary to the dictum of Guthrie and other distinguished authorities. But I was induced to do this for the following reasons: 1st. The patient was young, stout, and in good condition, and therefore his life was not immediately endangered. 2d. My experience and observation had taught me that cutting open wounds and tying bleeding vessels are much easier said than done, and not to be attempted except when imperatively demanded. 3d. On my first visit the hemorrhage, though not entirely checked, had so far subsided, that I thought myself justifiable in being governed by the sound maxim—"Never operate, unless the artery, however large, is bleeding."

On my second visit, the hemorrhage having entirely ceased, no call for further interference then existed. In this case I have no doubt that the brachial artery was opened by a slough, and yet the hemorrhage was happily controlled by means which may be emphatically pronounced *tute, cito, et jucunde.*